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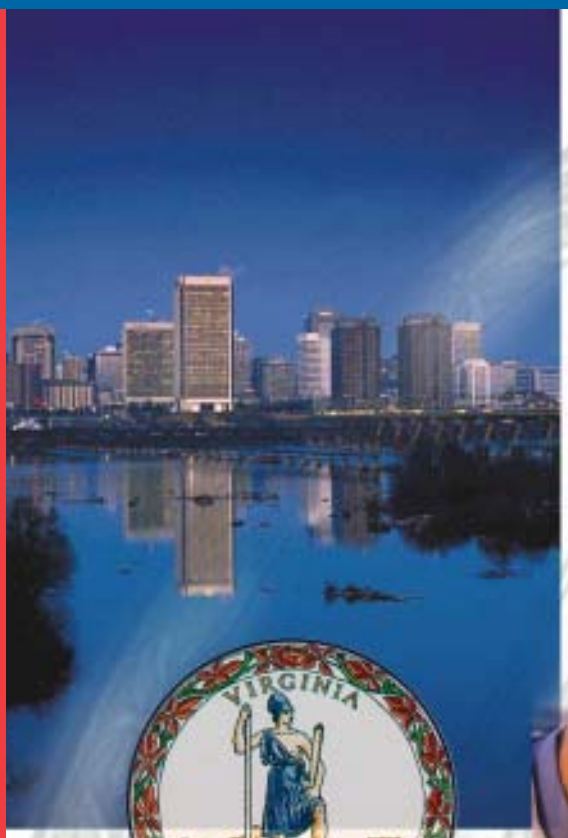

Commonwealth of Virginia Department of Medical Assistance Services

External Quality Review

Virginia Premier Health Plan

SFY 2005

We don't provide healthcare... we make it better.

Section II - Performance Improvement Projects

Introduction

As part of the annual External Quality Review (EQR), Delmarva conducted a review of Performance Improvement Projects (PIPs) submitted by each MCO contracting with the Department of Medical Assistance Services (DMAS). According to its contract with DMAS, each MCO is required to conduct PIPs that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. According to the contract, the performance improvement projects must include the measurement of performance using objective quality indicators, the implementation of system interventions to achieve improvement in quality, evaluation of the effectiveness of the interventions, and planning and initiation of activities for increasing or sustaining improvement.

The guidelines utilized for PIP review activities were CMS' *Validation of PIPs* protocols. After developing a crosswalk between the QIA form and *Validating PIP Worksheet,* Delmarva staff developed review processes and worksheets using CMS' protocols as guidelines (2002). CMS' *Validation of PIPs* assists EQROs in evaluating whether or not the PIP was designed, conducted, and reported in a sound manner and the degree of confidence a state agency could have in the reported results.

Prior to the PIP review for the 2003 review period (July through December 2003) training on the new validation requirements was provided to the Medallion II MCOs and Delmarva review staff. This training consisted of a four-hour program provided by Delmarva to orient the MCOs to the new BBA requirements and PIP validation protocols so that they would be familiar with the protocols used to evaluate their performance. CMS' validation protocols, *Conducting and Validating Performance Improvement Projects,* were presented to the MCOs in hardcopy during the training.

For the 2003 review period, the reviewers evaluated the entire project submission, although the minimum requirement was that each MCO review and analyze its baseline performance in 2003 to develop strong, self-sustaining interventions targeted to reach meaningful improvement.

For the current review period, calendar year (CY) 2004, the same protocols and tools were used. Reviewers evaluated each project submitted using the CMS validation tools. This included assessing each project across ten steps. These ten steps include:

Step 1: Review the Selected Study Topics

Step 2: Review the Study Questions
Step 3: Review the Selected Study Indicator(s)
Step 4: Review the Identified Study Population
Step 5: Review Sampling Methods
Step 6: Review the MCO's Data Collection Procedures
Step 7: Assess the MCO's Improvement Strategies
Step 8: Review Data Analysis and Interpretation of Study Results
Step 9: Assess the Likelihood that Reported Improvement is Real Improvement, and
Step 10: Assess Whether the MCO has Sustained its Documented Improvement.

As Delmarva staff conducted the review, each component within a standard (step) was rated as "yes," "no," or "N/A" (not applicable). Components were then rolled up to create a determination of "met", "partially met", "unmet" or "not applicable" for each of the ten standards. Table 1 describes this scoring methodology.

Table 1. Rating Scale for Performance Improvement Project Validation Review

Rating	Rating Methodology
Met	All required components were present.
Partially Met	One but not all components were present.
Unmet	None of the required components were present.
Not Applicable	None of the required components are applicable.

Results

This section presents an overview of the findings of the Validation Review conducted for each PIP submitted by the MCO. Each MCO's PIP was reviewed against all 27 components contained within the ten standards.

VA Premier provided the ten activities assessed for each PIP are presented in Table 2 below.

Table 2. 2004 Performance Improvement Project Review for VA Premier

Activity Number	Activity Description	Review Determination	
		Monitoring and Controlling the Management with the use of Two or More Atypical Antipsychotics	Quality Control in Asthma Management
1	Assess the Study Methodology	Partially Met	Met
2	Review the Study Question(s)	Unmet	Met
3	Review the Selected Study Indicator(s)	Unmet	Met
4	Review the Identified Study Population	Unmet	Met
5	Review Sampling Methods	Met	Met
6	Review Data Collection Procedures	Partially Met	Partially Met
7	Assess Improvement Strategies	Met	Partially Met
8	Review Data Analysis and Interpretation of Study Results	Met	Partially Met
9	Assess Whether Improvement is Real Improvement	Met	Partially Met
10	Assess Sustained Improvement	Met	Partially Met

Conclusions and Recommendations

Conclusions

VA Premier Health Plan (VA PREMIER) provided two PIPs for review. These included, (1) Monitoring and Controlling the Management with the Use of Two or More Atypical Antipsychotics, and (2) Quality Control in Asthma Management. These were evaluated using the Validating Performance Improvement Projects protocol, commissioned by the Department of Health and Human Services, Centers for Medicare and Medicaid Services, which allows assessment among 10 different project activities.

For the Atypical Antipsychotic Project, the MCO received a review determination of "Met" for five (5) elements, "Partially Met" for two (2) elements and Unmet for three (3) elements. For the Asthma Project, the MCO received a review determination of "Met" for five (5) elements and "Partially Met" for five (5) elements. None of the elements were "Unmet" for this project.

Recommendations

Based on a review of each of the two PIPs provided by the MCO, the following recommendations are made to improve the PIP process and performance.

- Improving provider compliance with clinical practice guidelines is not an appropriate study topic for a PIP (Monitoring and Controlling the Management with the Use of Two or More Atypical Antipsychotics project). A PIP should address system-wide issues, (enrollee, provider, and administrative) that present potential barriers to improved enrollee health outcomes.
- Describe a clear problem statement based upon analysis of data, which includes the actual or potential health consequences to the Medallion II population.
- Indicators need to be objective, clearly defined measures. Consider limiting the number of indicators and utilizing analysis of findings to drill down to additional detail and barriers relating to performance gaps. Cite references in clinical literature supporting association between improvements in selected indicators and changes in health status or valid proxy measures.
- Clearly define the identified study population to include age and enrollment requirements. Describe how VA PREMIER ensures that the data collection approach validly captures all Medicaid enrollees for each of the indicators.
- Clearly specify the data to be collected. Include a description of the data collection process, automated or manual. If automated, the degree of data completeness should be estimated. Provide evidence of an internal plan to ensure the collection of valid and reliable data for each indicator. If manual data collection is performed for any indicator, describe how the data collection instrument was designed to promote inter-rater reliability. Describe a prospective data analysis plan for each indicator. Qualifications of staff/personnel used to collect the data should be specified for all indicators.
- Ensure that a barrier analysis is completed after each measurement for all indicators.
- Consider analyzing data after each measurement period.
- The PIP report should include a description of the internal plan to ensure the collection of valid and reliable data for each indicator. Describe the degree of completeness of the automated data used for each study indicator. Identify how pharmacy data is to be collected. If manual data collection is performed for any indicator, describe how the data collection instrument was designed to promote inter-rater reliability. Describe a prospective data analysis plan for each indicator. Qualifications of staff/personnel used to collect the data should be specified for all indicators.
- Perform a barrier analysis for each indicator after each measurement period. Identify appropriate interventions for each indicator based upon identified opportunities for improvement.
- Perform a quantitative and qualitative analysis for each indicator after each remeasurement and ensure that the time period is clearly specified. For qualitative analysis identify barriers, opportunities, and interventions for each indicator. Avoid changes in methodology that impact comparability of results from one measurement period to another.

- Avoid changes in methodology that impact comparability of results from one measurement period to another. For the intervention to have face validity the analysis should describe how specific interventions contributed to the demonstrated success of each indicator.
- Strong, timely, and targeted interventions directly linked to identified barriers and opportunities for improvement should assist VA PREMIER in demonstrating sustained improvement through repeat measurements.

QUALITY IMPROVEMENT PROJECT
VALIDATION WORKSHEET

Use this or a similar worksheet as a guide when validating MCO/PHP Quality Improvement Projects. Answer all questions for each activity. Refer to the protocol for detailed information on each area.

ID of evaluator jaa Date of evaluation: July 2005

Demographic Information	
MCO/PHP Name or ID:	VA Premier Health Plan
Project Leader Name:	Jamie McPherson, Director, Quality Improvement
Telephone Number:	(804) 819-5179 Email: jmcpherson@vapremier.com
Name of Quality Improvement Project:	Quality Control in Asthma Management
Dates in Study Period:	January 1, 2002 to December 31, 2004 Phase: Remeasurement 2

I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY					
Step 1. REVIEW THE SELECTED STUDY TOPIC (S)					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care and services?	☒	☐	☐	VA Premier Health Plan (VA PREMIER) has analyzed national and plan specific data in selecting its study topic. Nationally asthma ranks as the sixth most common chronic condition and contributes to premature death if uncontrolled, lost work/school days, and use of high intensity medical services. Analysis of VA PREMIER MY 2003 data ranked asthma in the top five percent of diagnoses for all hospital admissions/emergency department visits for the Medallion II population.	QAPI RE2Q1 QAPI RE2Q2, 3,4 QIA S1A1
1.2 Did the MCO/PHP QIP address a broad spectrum of key aspects of enrollee care and services?	☒	☐	☐	This PIP seeks to decrease emergency department visits and hospital admissions for Medallion II enrollees who have been diagnosed with asthma. The PIP also includes a goal to increase the use of appropriate asthma medications. This PIP, over time, did address multiple care and delivery systems that have the ability to pose barriers to improved enrollee outcomes and meets the requirements of this element.	QAPI RE2Q1 QIA S1A2

I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY					
Step 1. REVIEW THE SELECTED STUDY TOPIC (S)					
1.3 Did the MCO/PHP QIP include all enrolled populations; i.e., did not exclude certain enrollees such as with those with special health care needs?	☒	☐	☐	This clinical PIP addresses care of all Medicaid HMO enrollees age 5-56 by December 31 of the measurement year who are identified as having persistent asthma. For all three indicators VA PREMIER followed the HEDIS eligible population description for Medicaid that contains inclusion and exclusion criteria.	QAPI RE2Q1 QIA S1A2

Assessment Component 1

☒ Met – All required components are present.

☐ Partially Met – Some, but not all components are present.

☐ Unmet -None of the required components is present.

Recommendations

Step 2: REVIEW THE STUDY QUESTION (S)					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
2.1 Was there a clear problem statement that described the rationale for the study?	☒	☐	☐	VA PREMIER presented a clear problem statement that described why this study was meaningful to the Medallion II population. According to VA PREMIER enrollees do not effectively manage their asthma condition with controller medications as evidenced by acute care utilization (hospital admissions and emergency department visits), which leads to poor health status and an increase in health care costs. Supporting data from the 2003 NCQA State of Health Care Quality Report was cited including a 45% reduction in the risk of repeat emergency department visits in patients using controller medications as compared with nonusers.	QIA S1A3

Assessment Component 2

☒ Met – All required components are present.

☐ Partially Met – Some, but not all components are present.

☐ Unmet -None of the required components is present.

Recommendations

Step 3: REVIEW SELECTED STUDY INDICATOR (S)					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
3.1 Did the study use objective, clearly defined, measurable indicators?	☒	☐	☐	Three indicators were identified for this study: one or more prescriptions for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers or methylxanthines (appropriate asthma medication) for enrollee with persistent asthma, rate of hospital admissions for enrollees with persistent asthma, and rate of emergency department visits for enrollees with persistent asthma. All indicators were objective, clearly and unambiguously defined, and based on current clinical knowledge. HEDIS methodology was utilized for identifying enrollees with persistent asthma.	QAPI RE3Q1, QAPI RE3Q2-6 QAPI RE3Q7-8 QIA S1B2 QIA S1B3
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	☒	☐	☐	Decreased inpatient admissions and emergency department visits as well as use of appropriate asthma medications have been identified as valid proxy measures for improved health status.	QAPI RE3Q9 QIA S1B1
Assessment Component 3 ☒ Met – All required components are present. ☐ Partially Met – Some, but not all components are present. ☐ Unmet -None of the required components are present.					
Recommendations					

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
4.1 Did the MCO/PHP clearly define all Medicaid enrollees to whom the study question(s) and indicator(s) are relevant?	☒	☐	☐	VA PREMIER clearly defined all Medicaid enrollees for each of the three indicators based upon HEDIS specifications. The eligible population included individuals 5-56 years of age by December 31 of the measurement year who were identified as having persistent asthma based upon meeting one of four criterion in the prior year.	QAPI RE2Q1, QAPI RE3Q2-6
4.2 If the MCO/PHP studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	☒	☐	☐	HEDIS specifications and methodology meet the requirements of this component for all indicators.	QAPI RE4Q1&2 QAPI RE5Q1.2 QIA I B, C

Assessment Component 4

☒ Met – All required components are present.

☐ Partially Met – One, but not all components are present.

☐ Unmet -None of the required components is present.

Recommendations

Step 5: REVIEW SAMPLING METHODS					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	☐	☐	☒	No sampling was used. VA PREMIER included the entire eligible population in the PIP.	QAPI RE5Q1.3a QIA S1C2
5.2 Did the MCO/PHP employ valid sampling techniques that protected against bias? *Specify the type of sampling or census used:*	☐	☐	☒	No sampling was used. VA PREMIER included the entire eligible population in the PIP.	QAPI RE5Q1.3b-c QIA S1C2
5.3 Did the sample contain a sufficient number of enrollees?	☐	☐	☒	No sampling was used. VA PREMIER included the entire eligible population in the PIP.	QAPI RE5Q1.3b-c QIA S1C2

Assessment Component 5

☒ Met – All required components are present.

☐ Partially Met – Some, but not all components are present.

☐ Unmet -None of the required components is present.

Recommendations

Step 6: REVIEW DATA COLLECTION PROCEDURES					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
6.1 Did the study design clearly specify the data to be collected?	☒	☐	☐	The "Baseline Methodology" section specified the data to be collected for the numerator and the denominator for each indicator. For all three indicators HEDIS methodology was utilized for identifying the eligible population (denominator). For the numerator for indicator #1 VA PREMIER used the NDC list provided by NCQA to identify appropriate prescriptions. For the numerator for indicators #2 and #3 diagnostic codes for asthma were identified as well as utilization data (emergency department visits, inpatient hospital admissions).	QAPI RE4Q1&2
6.2 Did the study design clearly specify the sources of data	☒	☐	☐	Sources of data were clearly identified for each indicator to include claims/encounter data and pharmacy data.	QAPI RE4Q1&2
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicator(s) apply?	☐	☒	☐	The data collection methodology for all three indicators was listed as a programmed pull from claims/encounter files of all eligible members as well as pharmacy data. There was no indication of the degree of completeness of automated data. It is unclear whether pharmacy data will be collected manually or through an automated system. Data collection was identified as once a year. There was no evidence of a plan to audit data to ensure validity and reliability for any of the three indicators for MY 2004 data.	QAPI RE4Q3a QAPI RE4Q3b QIA S1C1 QIA S1C3

Step 6: REVIEW DATA COLLECTION PROCEDURES					
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	☐	☒	☐	There was no evidence to support clear data collection instruments designed to promote inter-rater reliability for any manual data collection.	QAPI RE4Q1&2 QAPI RE4Q3b QAPI RE7Q1&2
6.5 Did the study design prospectively specify a data analysis plan?	☐	☒	☐	A prospective data analysis plan was not fully described, other than to state the frequency of the data analysis cycle.	QAPI RE5Q1.2
6.6 Were qualified staff and personnel used to collect the data?	☐	☒	☐	The PIP did not specify the qualifications of staff and personnel used to collect the data for any of the three indicators.	QAPI RE4Q4

Assessment Component 6

☐ Met – All required components are present.

☒ Partially Met – Some, but not all components are present.

☐ Unmet -None of the required components is present.

Recommendations

The PIP report should include a description of the internal plan to ensure the collection of valid and reliable data for each indicator. Describe the degree of completeness of the automated data used for each study indicator. Identify how pharmacy data is to be collected. If manual data collection is performed for any indicator, describe how the data collection instrument was designed to promote inter-rater reliability. Describe a prospective data analysis plan for each indicator. Qualifications of staff/personnel used to collect the data should be specified for all indicators.

Step 7: ASSESS IMPROVEMENT STRATEGIES					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	☐	☒	☐	There is evidence that VA PREMIER performed a limited barrier analysis but it is unclear what measurement period the barrier analysis addresses. Interventions related to the asthma medication indicator appeared appropriate based upon the administrative, provider, and enrollee barriers identified. There was no barrier analysis for the hospital admission or emergency department indicators. Rather VA PREMIER stated in PIP documentation that if enrollees were compliant with controller medications as measured by indicator #1 there would be improvements in these indicators as well. While clearly appropriate use of controller medications has the potential to reduce hospital admissions and emergency department visits there may be other factors contributing to this utilization, which should be analyzed. For instance, enrollees often utilize the emergency room for routine health care needs for convenience since they can receive same day care.	QAPI RE6Q1a QAPI RE6Q1b QAPI RE1SQ1-3 QIA S3.5 QIA S4.1 QIA S4.2 QIA S4.3

Assessment Component 7

☐ Met – All required components are present.

☒ Partially Met – Some, but not all components are present.

☐ Unmet -None of the required components is present.

Step 7: ASSESS IMPROVEMENT STRATEGIES
Recommendations Perform a barrier analysis for each indicator after each measurement period. Identify appropriate interventions for each indicator based upon identified opportunities for improvement.

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
8.1 Was an analysis of the findings performed according to the data analysis plan?	☐	☒	☐	A quantitative analysis of each indicator was performed following receipt of remeasurement 2 results. There was evidence of a qualitative analysis for the asthma medication indicator; however, it is unclear what measurement period this analysis addresses. There was no evidence of a qualitative analysis for indicators #2 and #3.	QAPI RE4Q4 QIA III
8.2 Did the MCO/PHP present numerical QIP results and findings accurately and clearly?	☒	☐	☐	The Data/Results Table accurately and clearly identified the rate, MCO goal, and benchmark for each indicator for each measurement period.	
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	☒	☐	☐	The analysis of results for the three indicators compared the second remeasurement to baseline and remeasurement 1. There was no analysis of remeasurement 2 with the comparison goal or benchmark. The PIP reported that remeasurement 2 results were not comparable to previous year's data due to a change in the requirement for continuous enrollment. This change also appears to impact comparability of results from remeasurement to 1 to baseline as well. A test of statistical significance was conducted for each indicator.	QAPI RE7Q2 QIA S1C4 QIA S2.1

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS					
8.4 Did the analysis of study data include an interpretation of the extent to which its QIP was successful and follow-up activities?	☐	☒	☐	The analysis included an assessment of the success of each indicator relative to past performance. A graph was included to illustrate the three year PIP trend for each indicator. The qualitative analysis section addressed opportunities and interventions for barriers identified for the appropriate asthma medication indicator. There was no barrier analysis for the other two indicators or related follow up activities identified.	QIA S2.2

Assessment Component 8

☐ Met – All required components are present.

☒ Partially Met – Some, but not all components are present.

☐ Unmet -None of the required components is present.

Recommendations

Perform a quantitative and qualitative analysis for each indicator after each remeasurement and ensure that the time period is clearly specified. For qualitative analysis identify barriers, opportunities, and interventions for each indicator.

Step 9: ASSESS WHETHER IMPROVEMENT IS REAL IMPROVEMENT					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
9.1 Was the same methodology as the baseline measurement used when measurement was repeated?	☐	☒	☐	The same methodology was not used according to PIP documentation. It appears that for remeasurement 2 for indicators #2 and #3 VA PREMIER no longer utilizes a continuous enrollment requirement for determining the eligible population. This precludes comparison of remeasurement 2 results with baseline and remeasurement 1 rates for both of these indicators. While there was no change noted for indicator #1 the denominator for all three measurement periods is identical to indicators #2 and #3 suggesting a change in enrollment eligibility criteria for this indicator as well.	QAPI RE7Q2 QAPI 2SQ1-2 QIA S1C4 QIA S2.2 QIA S3.1 QIA S3.3 QIA S3.4

Step 9: ASSESS WHETHER IMPROVEMENT IS REAL IMPROVEMENT					
9.2 Was there any documented quantitative improvement in processes or outcomes of care?	☒	☐	☐	Improvement from baseline to remeasurement 2 was evident for all three indicators. For use of appropriate asthma medications the rate increased from 62.0% to 70.6%. For the inpatient hospital admissions indicator the rate decreased from 20.8 to 6.4. For emergency department visits the rate decreased from 66.0 to 32.4. Improvement was also evident in all three indicators from remeasurement 1 to remeasurement 2. For the appropriate medication indicator the rate increased from 61.9 to 70.6. For the hospital admission indicator the rate decreased from 20.2 to 6.4. For the emergency department visit indicator the rate decreased from 78.9 to 32.4. These improvements in indicator rates, however, need to be carefully considered in light of the change in enrollment eligibility criteria for remeasurement 2.	QAPI RE7Q3 QIA S2.3

Step 9: ASSESS WHETHER IMPROVEMENT IS REAL IMPROVEMENT					
9.3 Does the reported improvement in performance have face validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	☐	☒	☐	All indicators demonstrated statistically significant improvement from remeasurement 1 to remeasurement 2. Face validity for the reported improvements cannot be established, however, since many of the interventions implemented in 2004 (remeasurement 2) did not occur until mid-year. For example, PCPs did not begin receiving a quarterly listing of enrollees who were currently receiving prescriptions for asthma without long-acting beta antagonist inhalers as well as enrollees who had been hospitalized or seen in the emergency department for an asthma diagnosis until May 2004. Primarily educational interventions directed at enrollees in 2003 may be responsible for some of the decrease but it is unlikely that education alone could have had such an impact.	QIA S3.2
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	☒	☐	☐	Using a Chi-square test there was a statistically significant increase in the appropriate asthma medication indicator for remeasurement 2 in comparison to both baseline and remeasurement 1. For both the hospital admission and emergency department visit indicators there was a statistically significant decrease for remeasurement 2 compared to baseline and remeasurement 1.	QIA S2.3

Step 9: ASSESS WHETHER IMPROVEMENT IS REAL IMPROVEMENT
Assessment Component 9 ☐ Met – All required components are present. ☒ Partially Met – Some, but not all components are present. ☐ Unmet -None of the required components is present.
Recommendations Avoid changes in methodology that impact comparability of results from one measurement period to another. For the intervention to have face validity the analysis should describe how specific interventions contributed to the demonstrated success of each indicator.

Step 10: ASSESS SUSTAINED IMPROVEMENT					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐	☒	☐	There was evidence to support sustained improvement for the appropriate asthma medication and hospital admission indicators. The emergency department visit indicator demonstrated an increase of 12.9 percentage points from baseline to remeasurement 1. As noted above, however, valid comparisons between remeasurement 2 and prior measurements are limited as a result of the change in enrollment eligibility requirements for the most recent period.	QAPI RE2SQ3 QIA II, III

Assessment Component 10

☐ Met – All required components are present.

☒ Partially Met – Some, but not all components are present.

☐ Unmet -None of the required components is present.

Recommendations

Strong, timely, and targeted interventions directly linked to identified barriers and opportunities for improvement should assist VA PREMIER in demonstrating sustained improvement through repeat measurements.

Key Findings for: ☐ Proposal ☒ Annual ☐ Resubmission ☐ Final
1. **Strengths** ➢ VA PREMIER researched and adopted well-established benchmarks from organizations including the National Committee for Quality Assurance and the Centers for Disease Control. One benchmark was obtained from Healthy People 2010. ➢ The study indicators were objective and well defined. ➢ A clear problem statement identified the importance of this study for the Medallion II population. ➢ HEDIS specifications were utilized to identify the eligible population. ➢ There was evidence of statistically significant improvement for all three indicators from baseline and remeasurement 1 to remeasurement 2.
2. **Best Practices** VA PREMIER identified PCPs with a high volume of enrollees with asthma and partnered with the PCP to place peak flow meters and spacers in their office to educate enrollees on proper use in real time and dispense as needed.
3. **Potential /significant issues experienced by MCO** (Barrier Analysis/Clarification Questions) Barriers identified included: ➢ Providers are not able to identify enrollees who need assistance in managing their asthma more effectively. ➢ Enrollees lack information regarding the asthma management program. ➢ Lack of continuous asthma education for enrollees. ➢ Lack of application of Plan guidelines related to asthma management. ➢ Lack of enrollees getting flu shots.

Key Findings for: ☐ Proposal ☒ Annual ☐ Resubmission ☐ Final

4. **Actions taken by MCO** (Barrier Analysis/Response to Clarification Questions)

Actions taken by the MCO included:

- PCPs receive a quarterly listing of enrollees with emergency department visits, inpatient hospital admissions, or who need appropriate asthma medication.
- All newly identified enrollees with a diagnosis of asthma will be sent a letter informing them of the asthma management program and contact information.
- Quarterly communications will be included in the provider newsletter on new formulary and asthma management strategies and resources. Educational information for enrollees will be included in the quarterly enrollee newsletter.
- VA PREMIER will partner with community-based agencies, hospitals, PHOs, and providers to present an annual training on Plan guideline related to asthma management.
- Enrollees with persistent asthma will be sent reminders to receive an annual flu shot.

Key Findings for: ☐ Proposal ☒ Annual ☐ Resubmission ☐ Final
5. **Recommendations for the next submission** (Pull from each Step Recommendations) ➢ The PIP report should include a description of the internal plan to ensure the collection of valid and reliable data for each indicator. Describe the degree of completeness of the automated data used for each study indicator. Identify how pharmacy data is to be collected. If manual data collection is performed for any indicator, describe how the data collection instrument was designed to promote inter-rater reliability. Describe a prospective data analysis plan for each indicator. Qualifications of staff/personnel used to collect the data should be specified for all indicators. ➢ Perform a barrier analysis for each indicator after each measurement period. Identify appropriate interventions for each indicator based upon identified opportunities for improvement. ➢ Perform a quantitative and qualitative analysis for each indicator after each remeasurement and ensure that the time period is clearly specified. For qualitative analysis identify barriers, opportunities, and interventions for each indicator. Avoid changes in methodology that impact comparability of results from one measurement period to another. ➢ Avoid changes in methodology that impact comparability of results from one measurement period to another. For the intervention to have face validity the analysis should describe how specific interventions contributed to the demonstrated success of each indicator. ➢ Strong, timely, and targeted interventions directly linked to identified barriers and opportunities for improvement should assist VA PREMIER in demonstrating sustained improvement through repeat measurements.
☒ The study design and methodology for this PIP submission meets PIP requirements. The EQRO recommends that the MCO continue with the project and report next year in the Spring of 2006 (exact time to be determined). ☐ The study design and methodology for this PIP submission does not meet PIP requirements. To meet requirements, we recommend the MCO resubmit the following by _____ (date): • (Action) • (Action)

QUALITY IMPROVEMENT PROJECT
VALIDATION WORKSHEET

Use this or a similar worksheet as a guide when validating MCO/PHP Quality Improvement Projects. Answer all questions for each activity. Refer to the protocol for detailed information on each area.

ID of evaluator jaa Date of evaluation: July 2005

Demographic Information	
MCO/PHP Name or ID:	VA Premier Health Plan
Project Leader Name:	Jamie McPherson, Director, Quality Improvement
Telephone Number:	(804) 819-5179 Email: jmcpherson@vapremier.com
Name of Quality Improvement Project:	Monitoring and Controlling the Management with the Use of Two or More Atypical Antipsychotics
Dates in Study Period:	July 1, 2004 to June 30, 2005 Phase: Remeasurement 1
Note: VA Premier submitted data for remeasurement I from January 1 to June 30, 2005 which is outside of this review period. It will be reviewed in 2006.	

I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY					
Step 1. REVIEW THE SELECTED STUDY TOPIC (S)					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care and services?	☒	☐	☐	VA Premier Health Plan (VA PREMIER) analyzed their Medallion II data in response to a recent finding nationally that has linked the development of diabetes and other metabolic abnormalities with prescribed atypical antipsychotics. Review of Medallion II data for MY 2004 revealed that 11.5% and 14.1% of enrollees were receiving treatment with two or more atypical antipsychotics from their physicians and psychiatrists respectively. Additionally, 13.6% and 23.7% of physicians and psychiatrists respectively prescribed treatment to enrollees of two or more atypical antipsychotics. While it is evident that VA PREMIER analyzed Medallion II data to select this study topic a PIP should focus on system-wide issues rather than provider compliance with clinical practice guidelines.	QAPI RE2Q1 QAPI RE2Q2, 3,4 QIA S1A1
1.2 Did the MCO/PHP QIP address a broad spectrum of key aspects of enrollee care and services?	☐	☒	☐	This PIP seeks to decrease the number of providers prescribing two or more atypical antipsychotics. As noted above improving provider compliance with clinical practice guidelines is not an appropriate study topic for a PIP. A PIP should address system-wide issues, (enrollee, provider, and administrative) that present potential barriers to improved enrollee health outcomes.	QAPI RE2Q1 QIA S1A2

I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY					
Step 1. REVIEW THE SELECTED STUDY TOPIC (S)					
1.3 Did the MCO/PHP QIP include all enrolled populations; i.e., did not exclude certain enrollees such as with those with special health care needs?	☒	☐	☐	This PIP addressed all enrollees prescribed atypical antipsychotics from a physician, psychiatrist or non-psychiatrist. There was no evidence that certain enrollees were excluded.	QAPI RE2Q1 QIA S1A2

Assessment Component 1

☐ Met – All required components are present.

☒ Partially Met – Some, but not all components are present.

☐ Unmet -None of the required components is present.

Recommendations

Improving provider compliance with clinical practice guidelines is not an appropriate study topic for a PIP. A PIP should address system-wide issues, (enrollee, provider, and administrative) that present potential barriers to improved enrollee health outcomes.

Step 2: REVIEW THE STUDY QUESTION (S)					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
2.1 Was there a clear problem statement that described the rationale for the study?	☐	☒	☐	There was no clear problem statement. The problem was stated as an increasing number of providers using two or more atypical antipsychotic medications for the same enrollee. There was no evidence to support increasing numbers. The problem statement did not include the actual or potential health consequences to the Medallion II population.	QIA S1A3

Assessment Component 2

☐ Met – All required components are present.

☐ Partially Met – Some, but not all components are present.

☒ Unmet -None of the required components is present.

Recommendations

Describe a clear problem statement based upon analysis of data, which includes the actual or potential health consequences to the Medallion II population.

Step 3: REVIEW SELECTED STUDY INDICATOR (S)					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
3.1 Did the study use objective, clearly defined, measurable indicators?	☐	☒	☐	Six indicators were identified for this PIP. Three indicators addressed the percentage of enrollees receiving treatment with two or more atypical antipsychotics prescribed by a physician (indicator #1), prescribed by a psychiatrist (indicator #2) and prescribed by a non-psychiatrist (indicator #3). Differentiation among provider types is unclear. For example, what is the difference between a physician and a psychiatrist since psychiatrists are physicians? The remaining three indicators address the percentage of physicians (indicator #4), psychiatrists (indicator #5), and non-psychiatrists (indicator #6) prescribing two or more atypical antipsychotics in the measurement year. These indicators present the same problem noted above in differentiating by provider type. Additionally, there were no criteria specified for defining age, enrollment, or atypical antipsychotic requirements for any of the indicators. While there are not only problems in defining the indicators the number of indicators are unnecessary. One indicator would be sufficient with analysis of findings isolating, for example, provider types.	QAPI RE3Q1, QAPI RE3Q2-6 QAPI RE3Q7-8 QIA S1B2 QIA S1B3

Step 3: REVIEW SELECTED STUDY INDICATOR (S)					
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	☐	☒	☐	While the PIP described a recent association between the development of diabetes and other metabolic abnormalities with atypical antipsychotics there was no evidence cited from clinical literature to support the improvement in selected indicators with improved health status.	QAPI RE3Q9 QIA S1B1

Assessment Component 3

☐ Met – All required components are present.

☐ Partially Met – Some, but not all components are present.

☒ Unmet -None of the required components are present.

Recommendations

Indicators need to be objective, clearly defined measures. Consider limiting the number of indicators and utilizing analysis of findings to drill down to surface additional detail and barriers relating to performance gaps. Cite references in clinical literature supporting association between improvements in selected indicators and changes in health status or valid proxy measures.

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
4.1 Did the MCO/PHP clearly define all Medicaid enrollees to whom the study question(s) and indicator(s) are relevant?	☐	☒	☐	VA PREMIER defined the identified study population as all enrollees receiving two or more atypical antipsychotics prescribed by a physician, psychiatrist, or non-psychiatrist in the measurement year. Age and enrollment criteria were not specified which is a component of a clearly defined study population.	QAPI RE2Q1, QAPI RE3Q2-6
4.2 If the MCO/PHP studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	☐	☒	☐	There was no information provided to support the existence of procedures to ensure that VA PREMIER's data collection approach captured all Medicaid enrollees for any of the indicators.	QAPI RE4Q1&2 QAPI RE5Q1.2 QIA I B, C

Assessment Component 4

☐ Met – All required components are present.

☐ Partially Met – One, but not all components are present.

☒ Unmet -None of the required components is present.

Recommendations

Clearly define the identified study population to include age and enrollment requirements. Describe how VA PREMIER ensures that the data collection approach validly captures all Medicaid enrollees for each of the indicators.

Step 5: REVIEW SAMPLING METHODS					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	☐	☐	☒	No sampling was used. VA PREMIER included the entire eligible population in the PIP.	QAPI RE5Q1.3a QIA S1C2
5.2 Did the MCO/PHP employ valid sampling techniques that protected against bias? *Specify the type of sampling or census used:*	☐	☐	☒	No sampling was used. VA PREMIER included the entire eligible population in the PIP.	QAPI RE5Q1.3b-c QIA S1C2
5.3 Did the sample contain a sufficient number of enrollees?	☐	☐	☒	No sampling was used. VA PREMIER included the entire eligible population in the PIP.	QAPI RE5Q1.3b-c QIA S1C2

Assessment Component 5

☒ Met – All required components are present.

☐ Partially Met – Some, but not all components are present.

☐ Unmet -None of the required components is present.

Recommendations

Step 6: REVIEW DATA COLLECTION PROCEDURES					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
6.1 Did the study design clearly specify the data to be collected?	☐	☒	☐	Data to be collected was not clearly specified based upon poorly defined, ambiguous indicators.	QAPI RE4Q1&2
6.2 Did the study design clearly specify the sources of data	☒	☐	☐	Pharmacy data was identified as the source of data for all indicators.	QAPI RE4Q1&2
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicator(s) apply?	☐	☒	☐	The data collection methodology was identified as pharmacy data with no indication of whether this data will be collected manually or through an automated system. If the data collection is automated the PIP should identify the degree of data completeness. Data collection was identified as twice a year. There was no evidence of a plan to audit data to ensure validity and reliability for any of the indicators for MY 2004 data.	QAPI RE4Q3a QAPI RE4Q3b QIA S1C1 QIA S1C3
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	☐	☒	☐	There was no evidence to support clear data collection instruments designed to promote inter-rater reliability for any manual data collection.	QAPI RE4Q1&2 QAPI RE4Q3b QAPI RE7Q1&2
6.5 Did the study design prospectively specify a data analysis plan?	☐	☒	☐	There was no evidence of a prospective data analysis plan. The data analysis cycle was identified as once a year.	QAPI RE5Q1.2
6.6 Were qualified staff and personnel used to collect the data?	☐	☒	☐	Qualifications of staff used to collect the data were not specified.	QAPI RE4Q4

Assessment Component 6

☐ Met – All required components are present.

☒ Partially Met – Some, but not all components are present.

☐ Unmet -None of the required components is present.

Step 6: REVIEW DATA COLLECTION PROCEDURES
Recommendations Clearly specify the data to be collected. Include a description of the data collection process, automated or manual. If automated, the degree of data completeness should be estimated. Provide evidence of an internal plan to ensure the collection of valid and reliable data for each indicator. If manual data collection is performed for any indicator, describe how the data collection instrument was designed to promote inter-rater reliability. Describe a prospective data analysis plan for each indicator. Qualifications of staff/personnel used to collect the data should be specified for all indicators.

Step 7: ASSESS IMPROVEMENT STRATEGIES					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	☒	☐	☐	VA PREMIER did not present evidence of a barrier analysis following collection of baseline data in the second half of calendar year 2004. Rather a barrier analysis was performed following remeasurement 1 that is outside of the scope of this review since it occurred in 2005. The Interventions Table for 2004 did identify the adoption and distribution of clinical practice guidelines to providers in response to an identified barrier resulting from lack of clinical guidelines. Providers were also notified of enrollees on their panel who were being treated with two or more atypical antipsychotics based upon provider lack of information regarding enrollees who were being treated with two or more antipsychotics. These interventions appeared to be reasonable in response to the barriers identified.	QAPI RE6Q1a QAPI RE6Q1b QAPI RE1SQ1-3 QIA S3.5 QIA S4.1 QIA S4.2 QIA S4.3

Assessment Component 7

☒ Met – All required components are present.

☐ Partially Met – Some, but not all components are present.

☐ Unmet -None of the required components is present.

Recommendations

Ensure that a barrier analysis is completed after each measurement for all indicators.

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
8.1 Was an analysis of the findings performed according to the data analysis plan?	☒	☐	☐	Data analysis was specified as once a year, however, each measurement period is six months. Data analysis was performed according to the plan, which addressed baseline and remeasurement 1 results separately for each indicator by measurement period (baseline and remeasurement 1) following conclusion of the second measurement period. The qualitative analysis was combined for all indicators and both measurement periods.	QAPI RE4Q4 QIA III
8.2 Did the MCO/PHP present numerical QIP results and findings accurately and clearly?	☒	☐	☐	The Data/Results Table accurately and clearly identified the rate and the comparison goal for each of the six indicators.	
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	☐	☐	☒	This is considered a baseline year for submission of this second PIP in compliance with a Department of Medical Assistance Services contractual requirement. Therefore, only 2004 measurements were reviewed.	QAPI RE7Q2 QIA S1C4 QIA S2.1
8.4 Did the analysis of study data include an interpretation of the extent to which its QIP was successful and follow-up activities?	☐	☐	☒	This is considered a baseline year for submission of this second PIP in compliance with a Department of Medical Assistance Services contractual requirement. Therefore, no analysis of the extent to which the PIP was successful and follow-up activities was required.	QIA S2.2

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS
Assessment Component 8 ☒ Met – All required components are present. ☐ Partially Met – Some, but not all components are present. ☐ Unmet -None of the required components is present.
Recommendations Consider analyzing data after each measurement period.

Step 9: ASSESS WHETHER IMPROVEMENT IS REAL IMPROVEMENT					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
9.1 Was the same methodology as the baseline measurement used when measurement was repeated?	☐	☐	☒	This is considered a baseline year for submission of this second PIP in compliance with a Department of Medical Assistance Services contractual requirement. Therefore, no repeat measurements will be reviewed during this cycle.	QAPI RE7Q2 QAPI 2SQ1-2 QIA S1C4 QIA S2.2 QIA S3.1 QIA S3.3 QIA S3.4
9.2 Was there any documented quantitative improvement in processes or outcomes of care?	☐	☐	☒	This is considered a baseline year for submission of this second PIP in compliance with a Department of Medical Assistance Services contractual requirement. Therefore, documented quantitative improvement in processes or outcomes of care was not reviewed during this cycle.	QAPI RE7Q3 QIA S2.3
9.3 Does the reported improvement in performance have face validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	☐	☐	☒	This is considered a baseline year for submission of this second PIP in compliance with a Department of Medical Assistance Services contractual requirement. Therefore, this component will not be reviewed during this cycle.	QIA S3.2
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	☐	☐	☒	This is considered a baseline year for submission of this second PIP in compliance with a Department of Medical Assistance Services contractual requirement. Therefore, this component will not be reviewed during this cycle.	QIA S2.3

Step 9: ASSESS WHETHER IMPROVEMENT IS REAL IMPROVEMENT
Assessment Component 9 ☒ Met – All required components are present. ☐ Partially Met – Some, but not all components are present. ☐ Unmet -None of the required components is present.
Recommendations

Step 10: ASSESS SUSTAINED IMPROVEMENT					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐	☐	☒	This is considered a baseline year for submission of this second PIP in compliance with a Department of Medical Assistance Services contractual requirement. Therefore, this component will not be reviewed during this cycle.	QAPI RE2SQ3 QIA II, III

Assessment Component 10

☒ Met – All required components are present.

☐ Partially Met – Some, but not all components are present.

☐ Unmet -None of the required components is present.

Recommendations

Key Findings for: ☐ Proposal ☒ Annual ☐ Resubmission ☐ Final
1. **Strengths** The study topic submitted does not meet the requirements for a performance improvement project.
2. **Best Practices** None identified.
3. **Potential /significant issues experienced by MCO** (Barrier Analysis/Clarification Questions) Barriers identified included: ➢ Lack of clinical guidelines. ➢ Lack of identified enrollees prescribed two or more atypical antipsychotics.
4. **Actions taken by MCO** (Barrier Analysis/Response to Clarification Questions) Actions taken by the MCO included: ➢ Adoption and distribution of clinical practice guidelines. ➢ Identification of enrollees on two or more atypical antipsychotics.

Key Findings for: ☐ Proposal ☒ Annual ☐ Resubmission ☐ Final

5. **Recommendations for the next submission** (Pull from each Step Recommendations)

- Improving provider compliance with clinical practice guidelines is not an appropriate study topic for a PIP. A PIP should address system-wide issues, (enrollee, provider, and administrative) that present potential barriers to improved enrollee health outcomes.
- Describe a clear problem statement based upon analysis of data, which includes the actual or potential health consequences to the Medallion II population.
- Indicators need to be objective, clearly defined measures. Consider limiting the number of indicators and utilizing analysis of findings to drill down to surface additional detail and barriers relating to performance gaps. Cite references in clinical literature supporting association between improvements in selected indicators and changes in health status or valid proxy measures.
- Clearly define the identified study population to include age and enrollment requirements. Describe how VA PREMIER ensures that the data collection approach validly captures all Medicaid enrollees for each of the indicators.
- Clearly specify the data to be collected. Include a description of the data collection process, automated or manual. If automated, the degree of data completeness should be estimated. Provide evidence of an internal plan to ensure the collection of valid and reliable data for each indicator. If manual data collection is performed for any indicator, describe how the data collection instrument was designed to promote inter-rater reliability. Describe a prospective data analysis plan for each indicator. Qualifications of staff/personnel used to collect the data should be specified for all indicators.
- Ensure that a barrier analysis is completed after each measurement for all indicators.
- Consider analyzing data after each measurement period.

Key Findings for: ☐ Proposal ☒ Annual ☐ Resubmission ☐ Final

☐ The study design and methodology for this PIP submission meets PIP requirements. The EQRO recommends that the MCO continue with the project and report next year on _____ (mo/yr).

☒ The study design and methodology for this PIP submission does not meet PIP requirements. To meet requirements, we recommend the MCO resubmit the following by date to be determined by DMAS and will be communicated to the plans.

- A study topic that meets the requirement of a performance improvement project and is based upon the analysis of Medallion II data.
- A clear problem statement based upon data analysis.
- Objective, clearly defined measurable indicators that measure changes in enrollee health, functional status or satisfaction or serve as valid proxy measures.
- A clear definition of the identified study population and procedures to ensure that the data collection approach captures all eligible enrollees.
- Well-defined data collection and analysis procedures for each study indicator.